Kansas
Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN
PLAN YEAR 2014
ACTIVE NON-STATE EMPLOYEE HEALTH PLAN GUIDEBOOK

Table of Contents

The information provided in this Employee Guidebook is subject to change without prior notice. Members are advised they should check the SEHP website and contact their HR office to verify they are using the most up to date version of this guidebook.

INTRODUCTION

This guide provides information to you on the State Employee Health Plan (SEHP). This guide should be read carefully and retained for reference. If there are additional questions, the employee should contact their Human Resources Office.

NOTE: This guide contains information which is current as of January 1,2014; however, benefit information is subject to change without notice. Go to this website and click on the link that contains the information that you are looking for:

www.kdheks.gov/hcf/sehp/default.htm

Note: *The information in this guide is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document or contract which contains the complete provisions of a program. In case of any discrepancy between this guide and the legal plan document or contract, the legal plan document or contract will govern in all cases. An employee may review the legal plan document or contract upon request. The State of Kansas reserves the right to suspend, revoke or modify the benefit programs offered to employees. Information contained in this guide, in the Non State Employer's Health Plan Administrative Manual and in the insurance provider's certificate/contract takes precedence over verbal information. Nothing in this guide shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.*

The SEHP is authorized by K.S.A. 75-6501 et seq. The program is governed by the State of Kansas Employees Health Care Commission (HCC) which is comprised of the following five members:

- The Secretary of the Kansas Department of Administration
- The Kansas Insurance Commissioner
- A retiree from classified State of Kansas service (appointed by the Governor)
- An active employee from classified State of Kansas service (appointed by the Governor)
- A person from the general public (appointed by the Governor)

Generally, the SEHP bids and contracts with health plans for three-year periods. The contractual periods of the medical, prescription drug, dental and vision are staggered so that not all contracts come due the same year.

All SEHP medical plans are self insured. These include:

- Blue Cross Blue Shield (Plan A, Plan B and Plan C – Qualified High Deductible Health Plan with Health Savings Account),
- Coventry Health Care (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account),
- United Healthcare (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)
- The prescription drug program is self-insured with Caremark contracted as the prescription benefit manager.

Other health plan benefits available under the SEHP:

- The dental plan is self insured and administered by Delta Dental Plan of Kansas.
- The voluntary vision plan is fully insured by Superior Vision.
- COBRA (Consolidated Omnibus Budget Reconciliation Act) administered by CobraGuard

For each self-insured plan, the SEHP pays the plan provider an administrative fee per contract to process membership information and claims. The SEHP and plan members are directly responsible for the payment of all claims and utilization costs. SEHP rates are based on the amount spent on claims and the utilization costs.

GENERAL DEFINITIONS USED IN THIS GUIDEBOOK:

A. COBRA Participant—a participant who elects a temporary extension of health coverage where such coverage would otherwise end as defined by the COBRA act of 1986.

B. Co-Insurance, Coinsurance—a cost-sharing requirement that provides that the member will be responsible for payment of a portion or percentage of the costs of covered services. It is a cost of health care that the member is responsible for paying, according to a fixed percentage or amount. Coinsurance is a type of cost sharing where the member and the plan share payment of the approved charge for covered services in a specified ratio after payment of the deductible.

C. Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)—a federal law requiring that most employers sponsoring Group Health Insurance Plans offer employees and their families an opportunity to extend health coverage for a limited period of time.

D. Co-Payment, Copayment—a cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as $40 for an office visit or $5 for each prescription drug). It does not vary with the cost of the service, unlike co-insurance which is based on a percentage of cost.

E. Deductibles—an amount that's required to be paid by the member before benefits become payable by the SEHP. Deductibles are usually expressed in terms of an "annual" amount.

F. Direct Bill and Retirees—a program to extend health coverage to: 1) retiring participating non state employees, 2) totally disabled former participating non state employees, 3) surviving spouses and/or dependents of participating non state employees eligible under the provisions of K.A.R. 108-1-3and 108-1-4 and 4) active participating non state employees who were covered under the health plan immediately before going on approved leave without pay.

G. Educational Employer Group (See also Qualified School district)—a public school district, community college, area vocational technical school, or technical college that meets the terms, conditions and other provisions established by the HCC and has entered into a written agreement with the HCC to participate in the SEHP.

H. Full-time Educational Employer Group (Qualified School District) Employee—the individual is an appointed or elective officer or employee of an educational employer group whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year.

I. Full-time Local Unit Employee—the individual is an appointed or elective officer or

employee of a qualified local unit whose employment sis not seasonal or temporary and whose employment requires more than 2,000 hours of work per year.

J. Health Care Commission (HCC)—the entity that establishes and oversees all provisions under the State Employee Health Plan.

K. Health Plan—defined medical, drug, dental and vision benefits offered to non state employees under the State Employee Health Plan.

L. HealthQuest—the State of Kansas Health Promotion Program, which is a wellness program administered by the State Employee Health Plan.

M. HIPAA—The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191) [HIPAA] was enacted by the U.S. Congress and signed by President Bill Clinton in 1996. It was originally sponsored by Sen. Edward Kennedy (D-Mass.) and Sen. Nancy Kassebaum (R-Kan.). Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The Administration Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

N. Local unit or entity—any of the following:
1) Any county, township, or city
2) Any community mental health center;
3) Any groundwater management district, rural water-supply district, or public wholesale water-supply district;
4) Any county extension council or extension district;
5) Any hospital established, maintained, and operated by a city of the first or second class, a county, or a hospital district in accordance with applicable law;
6) Any city, county, or township public library created under the authority of K.S.A. 12-1215 et seq., and amendments thereto;
7) Any regional library created under the authority of K.S.A. 12-1231, and amendments thereto;
8) Any library district created under the authority of K.S.A. 12-1236, and amendments thereto;
9) The Topeka and Shawnee county library district established under the authority of K.S.A. 12-1260 et seq., and amendments thereto;
10) The Leavenworth and Leavenworth county library district established under the authority of K.S.A. 12-1270, and amendments thereto;
11) Any public library established by a unified school district under the authority of K.S.A. 72-1623, and amendments thereto; or
12) Any regional system of cooperating libraries established under the authority of K.S.A. 75-2547 et seq., and amendments thereto;
13) Any housing authority created pursuant to K.S.A. 17-2337 et seq., and amendments thereto;
14) Any local environmental protection program obtaining funds from the state water fund in accordance with K.S.A. 75-5657, and amendments thereto;
15) Any city-county, county, or multicounty health board or department established pursuant to K.S.A. 65-204 and 65-205, and amendments thereto;

16) Any nonprofit independent living agency, as defined in K.S.A. 65-5101 and amendments thereto;
17) The Kansas guardianship program established pursuant to K.S.A. 74-9601 et seq., and amendments thereto; or
18) Any group of persons on the payroll of a county, township, city, special district or other local governmental entity, public school district, licensed child care facility operated by a not-for-profit corporation providing residential group foster care for children and receiving reimbursement for all or part of this care from the department of social and rehabilitation services, nonprofit community mental health center pursuant to K.S.A. 19-4001 et seq. and amendments thereto, nonprofit community facility for the mentally retarded pursuant to K.S.A. 19-4001 et seq. and amendments thereto, or nonprofit independent living agency as defined in K.S.A. 65-5101 and amendments thereto.

O. Local unit/entity plan—the local unit/entity employee health care benefits component of the heath care benefits program.

P. Member—individual who is eligible for and actively participates in the health care benefits offered through the State Employee Health Plan.

Q. Membership Services—the unit in the State Employee Health Plan that is responsible for all daily management of all eligibility functions and membership activities for all members who participate in the State Employee Health Plan. Members include Active state employees, Non-State Public Employer Group employees, Retirees, Direct Bill members and COBRA participants. The unit is also involved in managing and securing contracts with vendors that provide administrative services related directly to Membership programs.

R. Open enrollment period--refers to the period of time during which all members of the SEHP have the opportunity to enroll in and make plan changes to their SEHP. Open enrollment is only held once a year during the month of October. If a member misses the SEHP's annual open enrollment period, the member will not be able to enroll in or make any plan changes to their SEHP coverage until the next annual open enrollment period. Certain exceptions apply for new employees or employees with midyear qualifying events.

S. Part-time Educational Employer Group (Qualified School District) Employee—the individual is an appointed or elective officer or employee of an educational employer group whose employment is not seasonal or temporary and whose employment requires at least 630 hours of work per year.

T. Part-time Local Unit Employee—the individual is an appointed or elective officer or employee of an educational employer group whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year.

U. Plan year—annual time period for benefits in the SEHP. Begins at 12:01 a.m., Central Standard Time, on January 1, through midnight, December 31.

V. Premium—the total cost of the health plan option selected by the employee.

W. Qualified school district—a public school district, community college, area vocational technical school or technical college that meets the terms, conditions and other provisions established by the HCC and has entered into a written agreement with the HCC to participate in the SEHP.

X. School district plan—the school district employer health care benefits component of the health care benefits program.

Y. State Employee Health Plan (SEHP) —the state health care benefits program that may provide benefits for persons qualified to participate in the program for medical, prescription drug, dental, vision and other ancillary benefits to participating non state employees and their eligible dependents as defined under the provisions of K.A.R. 108-1-3 and 108-1-4. The program may include such provisions as are established by the Kansas state employees health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

Questions about the administration of the SEHP should be directed to the following address:

State Employee Health Plan
Membership Services
Room 900 – Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612-1220

Telephone: (785) 296-3226
Fax: (785) 368-7180

Email: benefits@kdheks.gov

Visit our website at: http://www.kdheks.gov/hcf/sehp/default.htm

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. HIPAA places requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations that:

1 limit exclusions for preexisting conditions;
2 prohibit discrimination against employees and dependents based on their health status; and
3 guarantee renewability and availability of health coverage to certain employees and individuals.

PRE-EXISTING CONDITION EXCLUSIONS

The SEHP does not have a waiting period for coverage of pre-existing conditions.

CREDITABLE COVERAGE

The group health plan is required to furnish a certificate of coverage automatically when coverage terminates either with the SEHP or when coverage is lost under COBRA continuation, as well as upon an individual's written request at any time while that person is covered by a plan or up to 24 months after coverage ceases. Plans are also required to use reasonable efforts to determine information needed to complete a certificate for a dependent. Creditable coverage is coverage under most health benefit programs, including employer or multiemployer group health plans, individual health insurance policies, COBRA continuation coverage, Medicare, Medicaid, and state and local government programs, including health coverage provided by SCHIP and by a foreign government. Certification will be sent to the individual or dependent at their last known address and will identify the covered person, the period of coverage, any waiting periods, and will include an educational statement to inform recipients of their HIPAA rights, and information about FMLA coordination. Also under the Trade Act of 2002, workers qualifying for the provisions of the Trade Act have a second opportunity to elect COBRA after an original qualifying event.

SPECIAL ENROLLMENTS

HIPAA requires that group health plans allow individuals to enroll without having to wait for late or open enrollment. These special enrollment periods are for individuals who previously declined coverage for themselves and their dependents. A special enrollment period can occur if: (1) a current employee or dependent with other health coverage loses eligibility for coverage, or (2) a person becomes a dependent through marriage, birth, adoption or placement for adoption. The employee needs to complete enrollment within 31 days after their other coverage ends. Written documentation of the marriage, birth, adoption or placement for adoption must be provided.

Some examples where special enrollment would apply are: 1) ceasing to be eligible under a plan due to cessation of dependent status (e.g. a child aging out of dependent coverage); 2) reaching a plan's lifetime limit on all benefits; 3) a plan ceasing to offer any benefits for a class of similarly situated individuals (e.g. all part-time workers); and 4) an employer of another plan stops contributions toward other coverage, even if the individual continues the other coverage by paying the amount that used to be paid by the employer.

NONDISCRIMINATION REQUIREMENTS

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals on these factors. These factors are: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability or disability. For example, an individual cannot be excluded or dropped from coverage under the health plan just because the individual has a particular illness.

OTHER APPLICATIONS OF HIPAA LAW

HIPAA provisions also apply to services under the following laws: 1) Women's Health and Cancer Rights Act (WHCRA) which provides protections to patients who choose to have breast reconstruction in connection with

a mastectomy; 2) Mental Health Parity Act (MHPA) which prevents the group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan; and, 3) Newborns' and Mothers' Health Protection Act (NMHPA) which affects the amount of time the member or beneficiary and newborn child are covered for a hospital stay following childbirth. For the mother or newborn child, that includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not in excess of the above periods. 4) The Genetic Information Nondiscrimination Act of 2008 generally prohibits the discrimination on the basis of genetic information as well as the release of your genetic information.

PLAN DISCLOSURE REQUIREMENTS

Under the Department of Labor's (DOL) rules governing plan disclosure requirements, group health plans must improve the summary plan descriptions and summaries of material modifications in the following ways: 1) Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of adoption of the change; 2) Disclose information about the role of insurance companies and health plans with respect to the group health plan, specifically the name and address, and to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims; 3) Inform members and beneficiaries which DOL office they can contact for assistance or information on their rights under HIPAA; and 4) Inform members and beneficiaries that federal law prohibits the plan and health insurance issuer from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

PLAN MEMBERS RIGHTS

Should you have questions about your rights under HIPAA, you may contact the following office:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

HIPAA ADMINISTRATIVE SIMPLIFICATION

The Administrative Simplification provisions of the HIPAA (Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

PRIVACY REGULATIONS

The privacy regulations (effective April 14, 2003) ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these standards include: 1) Access to medical records; 2) Notice of privacy practices; 3) Limits on use of personal medical information; 4) Prohibition on marketing, and stronger state laws; 5) Confidential communications; and 6) Where to file complaints.

SECURITY REGULATIONS

The HIPAA Security requirements (effective April 20, 2005) ensure confidentiality of electronic protected health information that the health plan creates, receives, maintains or transmits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective January 1, 1999, the Federal Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance companies, and health maintenance organizations (HMOs) that provide benefits for mastectomies to also provide coverage for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes). The deductible and coinsurance provisions applicable to these benefits are consistent with the deductible and coinsurance provisions governing other benefits provided by the State Employee Health Plan. Coverage will be provided in a manner determined from consultation with the attending physician and the patient.

Any questions concerning the above benefits provided under the State Employee Health Plan should be directed to your medical plan.

EMPLOYEE ELIGIBILITY

According to provisions of K.A.R. 108-3-1 and 108-4-1, the classes of persons eligible to participate in the State Employee Health Plan shall be the following classes of persons:

A. Educational Employer Group/Qualified School District employee—any individual who is employed by an education employer group/qualified school district and who meets the definition of employee under K.S.A. 74-4932(4), and amendments thereto, whose employment is not seasonal or temporary and requires at least:

1. 630 hours of work per year for part-time status or;

2. 1,000 hours of work per year for full-time status

B. Qualified Local unit employee—any individual who meets one or more of the following criteria:

1. The individual is an appointed or elective officer or employee of a qualified local unit whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year for part-time employees and more than 2,000 hours of work per year for full-time employees.

2. The individual is an appointed or elective officer or employee who is employed concurrently by two or more qualified local units in positions that involve similar or related tasks and whose combined employment by the qualified local units is not seasonal or temporary and requires at least 1,000 hours of work per year for part-time employees and more than 2,000 hours of work per year for full-time employees.

3. The individual is a member of a board of county commissioners of a county that is a qualified local unit, and the compensation paid for service on the board equals or exceeds $5,000 per year.

4. The individual is a council member or commissioner of a city that is a qualified local unit, and the compensation paid for service as a council member or commissioner equals or exceeds $5,000 per year.

Eligible employees who elect to participate in the SEHP are referred to as member(s) throughout this guidebook.

EMPLOYEE WAITING PERIOD

If you are in one of the classes listed above, you have 31 days from your first day of employment with the qualified school district or local unit to elect or waive SEHP coverage. If you enroll in the SEHP, your coverage will be effective the first day of the month following completion of a 30-day waiting period starting from your first day of employment. If you miss this deadline, the next opportunity you have to elect coverage will be at annual Open Enrollment. There may be certain situations or conditions in which the 30-day waiting period may not apply. Please contact your Human Resources office for additional information.

Waiver of the Waiting Period

Under certain circumstances, the 30-day waiting period in K.A.R. 108-1-3 and 108-1-4 may be waived. **Before the prospective employee's acceptance of the position**, the chief administrative officer or designee must certify in writing, to the Kansas State Employees Health Care Commission (HCC) or its designee that the waiver is being sought for either of the following reasons:

I. The new employee is not entitled to continuation of health benefits under either Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, or state continuation of coverage laws, K.S.A. 40-2209 and K.S.A. 40-3209 and amendments thereto, and is not covered by or eligible to be covered by another health insurance plan;

II. The new employee is required to have health insurance as a condition of obtaining a work visa for employment in the United States.

The chief administrative officer or designee must complete and submit a Request for Waiver of the 30-Day Waiting Period Form along with the written request for waiver within 30 days of the date of your hire.

If the 30-day waiting period is waived, your part of the premium must initially be paid on an after-tax basis. You may change to the pre-tax premium option effective the 1st day of the month that your coverage would have become effective without the waiver. If you desire to change to the pre-tax option after this period of time, your HR Representative must submit an online Change Request must be with the original Enrollment Request.

EFFECTIVE DATE OF COVERAGE

Your initial enrollment period for the SEHP is limited. Your Human Resource representative should complete an online Initial Enrollment request within 31 days of your starting date in a benefits-eligible position, and then you will be responsible for making your elections online via the **Kansas employee eligibility portal**. The effective date of your coverage will be the 1st day of the month following the completion of the waiting period, provided that the SEHP Membership Services receives the online request within 31 days from your date of hire. Once your benefits have become effective, no changes to your elections can be made unless you experience a qualifying event.

If your request for a waiver of the waiting period was approved (see prior section), the effective date of coverage is the 1st day of the month following your date of hire. If your date of hire is the 1st day of a month, your coverage will begin on that day.

If you are a current employee who is changing from a non-benefits eligible position to a benefits eligible position, and who has already served the 30-day waiting period, your enrollment period is 31 days from the date the you started working in the eligible position. SEHP Membership Services must receive your Initial Enrollment request with 31 days from the date you were enrolled in the eligible position. Your effective date of coverage is the 1st day of the month following your starting date in the eligible position, as long as you have worked in the non-eligible position for more than 30 days prior. If your starting date in the eligible position is on the 1st day of the month, your coverage will begin on that day.

If you were rehired and your break in service is 30 calendar days or less, your effective date of coverage is the 1st day of the month following your rehire date (if you had SEHP coverage in effect prior to your break in service). If your rehire date is the 1st day of the month, your coverage effective date will be the 1st day of that month. If you are rehired or reactivated within 30 days, you must enroll in the same coverage you previously had, unless you experience a qualifying event.

Corrected Initial Enrollment requests will be approved only if completed and received by the SEHP Membership Services before the initial coverage election has taken effect.

PRE-EXISTING CONDITIONS

The SEHP does not have a waiting period for pre-existing conditions. Certificates of Creditable Coverage from any other medical plan you were covered by are not required for enrollment.

WAIVER OF INSURANCE COVERAGE

If you elect to waive SEHP coverage, you must still access the Initial Enrollment portal online and indicate that you wish to waive SEHP coverage. The waive selections must be submitted via the Initial Enrollment portal during your enrollment period. If you do not submit plan elections in the Initial Enrollment portal within the 31 day enrollment period, you will be defaulted to waived coverage with the SEHP.

FULL-TIME/PART-TIME STATUS

Your contributions for your SEHP coverage Plan Year are dependent upon whether your position is full-time or part-time. If you are active in more than 1 eligible position, your employment status is based on the combined FTE (Full Time Equivalent) for all positions.

HEALTH PLAN SALARY RANGE

The Health Plan salary range is the range in which as of January 1 each year, your annual salary falls within. If you were newly hired during the Plan Year, the annual salary is as of your date of hire. If you are a current employee with new benefits eligibility, your annual salary is as of the date of benefits eligibility.

Your contributions for SEHP coverage during the Plan Year are dependent upon your salary range as outlined below (if you are active in more than 1 eligible position, the annual salary range is based on the combined salary for all positions):

Annual Salary Ranges
Salary Range 1 = Less than $28,000
Salary Range 2 = $28,000 - $48,000
Salary Range 3 = More than $48,000

Your salary range is not changed during the Plan Year. The only exception is if your salary range changes from a full-time to a part-time position or from a part-time to a full-time position.

Prior to the beginning of a new Plan Year, the SEHP is responsible for updating your salary range. During the plan year, the SEHP will only change the salary tier for you if you change from Full-time to Part-time status or vice versa.

The Qualified High Deductible Health Plan deduction is not dependent on your salary range.

Before your HR representative can submit an online Enrollment, Change, or other SEHP request, it is your responsibility to make sure that:

- You have given your HR demographic information for you and any dependents to be added;
- You have given your HR contact information including address, phone number, and email;
- You have included all documentation that is required in order to make the change.

Please contact your Human Resources office for additional information.

DENTAL PLAN

Member only dental coverage is provided for all members enrolled in medical coverage. If you choose to enroll your dependents in dental coverage the same dependents enrolled in dental coverage must be enrolled in medical coverage. Dependent dental coverage may not be dropped during the plan year unless dependent medical coverage is also dropped.

VISION PLAN

If you choose dependent vision coverage, and dependent children are also enrolled in the medical plan, the dependent children enrolled in the vision plan must match those enrolled in the medical plan. Please note that

you can enroll or change your vision coverage only when you or a dependent first becomes eligible, during the annual open enrollment period, or if a dependent becomes ineligible. This holds true even if you pay your premiums on an after-tax basis.

OTHER ELIGIBLE INDIVIDUALS UNDER THE SEHP

In addition to covering yourself, you may also elect coverage for other eligible individuals of your family. These eligible individuals include:

1. Your lawful wife or husband, referred to as "spouse" throughout the rest of this guidebook (Same gender marriages are not recognized under Kansas Law).
2. Any of your eligible dependent child(ren) also referred to as "dependent(s)" throughout the rest of this guidebook.

If you divorce, coverage for your former spouse and stepchild(ren) ends on the last day of the month of the date your divorce is filed. If the date of your divorce is the first day of the month, coverage for your former spouse and stepchild(ren) ends on the first day of that month.

Other Eligible Individuals Important Information:

A. If you are eligible to enroll as a primary member in the SEHP, you are not eligible to be enrolled as spouse or dependent of another primary member in the SEHP.

B. An eligible dependent that is enrolled by one primary member is not eligible to be enrolled as a dependent by another primary member.

C. "Other eligible individual" excludes any individual who is not a citizen or national of the United States, unless the individual is a resident of the United States or a country contiguous to the United States, is a member of a primary member's household, and resides with the primary member for more than six months of the calendar year. The dependent shall be considered to reside with the primary member even when the dependent is temporarily absent due to special circumstances, including illness, education, business, vacation, and military service.

D. "Permanent and total disability" means that an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have permanent and total disability unless the individual furnishes proof of the permanent and total disability in the form and manner, and at the times, the SEHP may require.

E. The word "child" means:

1) Your natural son or daughter
2) Your lawfully adopted son or daughter. Lawfully adopted will include those instances in which a primary member has filed a petition for adoption with the court, has a placement agreement for adoption or has been granted legal custody.
3) Your stepchild. If the natural or adoptive parent of the stepchild is divorced from you, the child no longer qualifies as your stepchild, and is no longer eligible for coverage.
4) A child of whom you as the primary member has legal custody. Legal custody ends once the child reaches the age of 18.
5) Your grandchild, if at least one of the following conditions is met:
    I. You have legal custody of your grandchild or have lawfully adopted your grandchild
    II. The grandchild lives in the your home and is the child of your covered eligible dependent child and you provide more than 50% of the support of your grandchild; or
    III. The grandchild is the child of your covered eligible dependent child and is considered to reside with you even when your grandchild or your eligible

dependent child is temporarily absent due to special circumstances including education of your covered eligible dependent child, and you provide more than 50% of the support for the grandchild.

F. Eligible dependent child(ren) or stepchild(ren). To be covered under the SEHP, your child or stepchild must be less than 26 years of age.

G. Eligible dependent child(ren) or stepchild(ren) aged 26 or older who have a permanent and total disability as described in Section D above and has continuously maintained group coverage as an eligible dependent of yours before reaching the limiting age to be covered under the plan. The child must be chiefly dependent on the primary member for support (receive more than 50% of his or her support and maintenance from the primary member.)

DEPENDENT DOCUMENTATION REQUIREMENT:

The State of Kansas and the SEHP require supporting dependent documentation to support proof of dependency and/or residency of your dependents (spouses, children, grandchildren, etc.). When requesting to enroll your dependent(s) for coverage with the SEHP, you must certify:

1. That your dependent(s) meet the requirements for dependent coverage for the year in which the dependent(s) are being enrolled.

2. You must also provide appropriate supporting documentation for each dependent at the time you are requesting to add them (such as the birth certificate, adoption papers, marriage license, copy of the current year's filed federal tax return, etc. See additional information below).

3. Any attempt to enroll dependent(s) who do not meet the SEHP requirements will be considered fraud and will be subject to penalties as prescribed by law.

Note: Requests that are submitted without supporting dependent documentation or with incomplete documentation will be denied with no action taken by the SEHP. The deadline for submitting the request will not be extended and the dependent will not be added to your SEHP coverage

DEPENDENT'S EFFECTIVE DATE OF COVERAGE

Your dependents shall become newly eligible on the later of:

1. Your initial date of eligibility; or

2. The 1st day of the month following the date the individual first becomes your dependent or becomes newly eligible for coverage according to the dependent definition. The newly eligible dependent must be added to your coverage within 31 days of the date you gain the new dependent or within 31 days of the date the dependent becomes newly eligible according to the dependent definition.

3. The 1st day of the month following the loss of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. The newly eligible dependent must be added to coverage within 60 days of the date of the loss of Medicaid or SCHIP coverage.

NEWLY ELIGIBLE DEPENDENTS

You must inform your HR of any newly eligible dependent(s) you wish to add within 31 days of the event that makes the dependent(s) newly eligible.

Coverage for newly eligible dependents may be added if you are enrolled in the SEHP on a pre-tax or an after-tax basis.

The change in coverage must be consistent with the event and/or must comply with HIPAA regulations.

Supporting documentation is required (copy of the birth certificate, petition for adoption, marriage license, legal custody agreement, copy of current year's filed federal tax return, etc.) as proof of the qualifying event. Please see the section below that outlines in detail the documents that must be submitted to the SEHP. Requests that are submitted without documentation or with incomplete documentation will be denied, and notice of the denial will be sent to your Human Resources office with no action taken by the SEHP. Any documentation submitted in any other language besides English must be accompanied with an English translation. The deadline for submitting the request will not be extended.

The following appropriate documentation is required to be submitted to the SEHP with the Enrollment or Change Request:

1. Marriage License (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement for newborns including full name of the parent(s). **(Birth registration cards are not acceptable proof for newborns)**
3. Petition for adoption or placement agreement for dependent child
4. Legal custody or guardianship document issued by the court
5. Court order for dependents who are not natural or adopted children of the primary member
6. Certificate of birth and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild)
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older
8. Copies of the current year's filed Federal tax return (for proof of spouse eligibility only.) **Please note all income information may be whited out prior to submission to SEHP Membership Services.** The pages needed from the current year's filed Federal tax return depends on which Tax form was filed:
   - Form 1040—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 1040A—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 8879 (IRS *e-file*)—containing the date filed, the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
9. Divorce decree (Only the first and last page of the court document are needed, but those pages must include the date stamp by the court and the signature of the judge)
10. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.
11. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

Social Security and Individual Taxpayer Identification Numbers

According to Section 111 of the Federal Medicare, Medicaid, and SCHIP Extension Act of 2007 (the "Act"), group health plans are required to report eligibility information to the Centers for Medicare and Medicaid Services (CMS) for purposes of coordination of benefits. To satisfy the mandate, the SEHP is

required to obtain valid Social Security Numbers (SSNs), Medicare Health Insurance Claim Number (HICN) or Individual Taxpayer Identification Number (ITIN) for non-resident alien individuals and their eligible dependents. Dependents include a spouse and other family members eligible to be covered by health plan benefits.

A HICN is the number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. The SSN is used as the basis for the Medicare HICN. While the HICN is required to identify a Medicare beneficiary, if the HICN is not available some beneficiaries may also be identified by the SSN. Please note that CMS has a longstanding practice of requesting HICNs or SSNs for coordination of benefit purposes.

Individual Taxpayer Identification number (ITIN): A non-resident alien individual engaged or considered to be engaged in a trade or business in the United States during the year is required to file a federal tax return each year. As a result, they must apply for an ITIN. These numbers are unique identifiers similar to SSNs and have the first 3 digits in the range of 900-999.

In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of HICN, SSN or ITIN numbers as applicable. The SEHP requires valid SSNs or ITINs for all eligible members to participate in the SEHP to ensure the Plan is in compliance with the Act.

- Newborn children—the valid SSN must be provided to SEHP Membership Services within **60 days** of the child's date of birth.
- Non-resident alien individuals or their eligible dependents—the valid ITIN must be provided to SEHP Membership Services within the **first 30 days of enrollment** in the SEHP. If an ITIN cannot be provided within this time frame, an online Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

If the SSN or ITIN is not provided within these time periods, the dependent may be removed from the SEHP. A copy of the SSN or ITIN card can be provided as documentation.

NOTE: Valid SSNs/ ITINs are required during annual Open Enrollment for any newly added dependents. If the information is not provided during Open Enrollment the dependents will not be added to the SEHP in the following plan year. If an ITIN cannot be provided by the annual Open Enrollment deadline, an online Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

Please contact your Human Resources office for additional information.

NEWBORNS OR ADOPTIONS

Adding a Newborn to Your SEHP Coverage for coverage tier 1 (Employee Only) or tier 2 (Employee + Spouse)

An online change request must be submitted by your HR Representative to SEHP Membership Services within 31 days of the date of your newborn's birth to add them to your SEHP benefits. Appropriate dependent documentation and a valid SSN or ITIN are also required and should be sent at the same time as the change

request. This information must be submitted to SEHP Membership Services within 31 days of the date of your newborn's birth. For grandchildren, a copy of the birth certificate and a completed Dependent Grandchild Affidavit must be submitted with the Change Request. If the change request, SSN/ITIN and appropriate supporting dependent documentation is not received within the above time frame, the dependent will not be added for coverage.

- If you already have spouse coverage, your newly eligible dependent will have medical claims paid for only the first 31 days from the date of birth. Medical claims payment for your newborn ends on the 32nd day. If your child is successfully added within the first 31 days of their birth, claims payment will continue and a coverage level change to Employee and Family and an appropriate premium change will occur the first of the month following the date of birth of your newborn.
- If you have single coverage, your newly eligible dependent will have medical claims paid for only the first 31 days from the date of birth. Medical claims payment for your newborn ends on the 32nd day. If your child is successfully added within the first 31 days of their birth, claims payment will continue and an appropriate change in coverage level and premium change will occur the first of the month following the date of birth of your newborn

Adding a Newborn to Your SEHP Coverage for coverage tier 3 (Employee + Children) or tier 4 (Employee + Family)

Effective October 1, 2013, if you already have children or family coverage, your newly eligible dependent will have medical claims paid continuously beyond the first 31 days from the date of birth however the child is not permanently added to your SEHP coverage, unless a change request, SSN/ITIN and proper documentation is provided to SEHP Membership Services. Members are still required to properly notify the SEHP of the birth of the newborn, provide a valid SSN/ITIN and appropriate dependent documentation. If the change request, SSN/ITIN and appropriate supporting dependent documentation is not received, claims payment for your dependent will end and your newborn will not be permanently added to your SEHP coverage.

NOTE: Regarding a newborn child of your dependent child (grandchild); your grandchild will only be covered for the first 5 days from the date of birth. Coverage for your grandchild will end on the 6th day if your do not notify your HR Representative and have them complete a Change Request to add your dependent grandchild to coverage (along with appropriate supporting dependent documentation) within 31 days from the date of birth. SEHP Membership Services must receive the Change Request within 31 days of the date of birth.

In the case of adoption, your dependent must be added to your coverage within 31 days of the date that the petition for adoption or placement notice is filed or the date of adoption placement. A copy of the petition for adoption or placement notice must be uploaded along with the online Change request.

If the adoption is being handled through an adoption agency, they may require an adjustment period in your home prior to filing the petition for adoption. In this case, a copy of the adoption agency's placement letter must be uploaded along with the online Change request and must indicate the date of placement as well as the length of the adjustment period. When the adjustment period is over and the petition for adoption has been filed with the court, you must submit a copy of the petition for adoption in order to continue coverage for the dependent. If the dependent is removed from your home, or the petition for adoption is not filed, an online Change request must be submitted to remove the dependent from your coverage.

Your Human Resources office should contact SEHP Membership Services for guidance if the dependent is being adopted and a petition for adoption is never filed in a U.S. court (which is sometimes the case with foreign adoptions).

Effective Date of Coverage

If the date of the filing for petition for adoption or placement in your home is within 31 days of the birth of the child, the coverage effective date is the date of birth provided the SEHP Membership Services receives documentation within 31 days of the birth of the child. If the filing placement is not within 31 days of the date of birth of the child, the effective date of coverage is the date of the filing date of the petition for adoption **or** the date of placement, whichever the case may be. The effective date of coverage cannot be earlier than the child's placement or arrival your home within the United States.

If you add a newly eligible newborn or adopted dependent to coverage, you may add other eligible dependents to your coverage. The effective date of coverage for the newborn or adopted dependents will be the date of birth if an online Change request is completed within 31 days of the applicable child's birth. The effective date of coverage for other eligible dependents, such as your spouse and/or other children or stepchildren of yours, will be the first day of the month following the birth, date of placement for adoption or date of petition for adoption.

Change in Employee Contribution

The change in coverage will be reflected in your contribution beginning the 1st of the month following the date of birth, date of petition for adoption or date of the placement agreement. If the date of birth, date of petition for adoption, or date of the placement agreement occurs on the 1st day of the month, the change in your contribution shall not take place until the 1st of the following month.

New Legal Custody/Guardianship Dependents (for dependents who are not natural or adopted children of the member)

If you are adding a newly eligible legal custody/guardianship dependent to coverage, you must have your HR complete an online Change request to add the dependent to coverage within 31 days of the date that the court issues a legal custody agreement. A copy of the court order or legal custody agreement must be uploaded along with the online Change request.

The effective date of coverage will be the 1st day of the month following the date of legal custody or guardianship. If the date of legal custody or guardianship occurs on the 1st day of a month, the coverage effective date will be the 1st day of the month.

Your contributions will be due according to the dependent coverage effective date.

NEW SPOUSE OR STEPCHILDREN DUE TO MARRIAGE

If you want to add other newly eligible dependents to coverage due to marriage, you must have your HR complete an online Change request adding the dependents to coverage within 31 days of the event (marriage). SEHP Membership Services must receive the appropriate request along with appropriate supporting documentation.

The effective date of coverage will be the 1st day of the month following the date of marriage. If the marriage occurs on the 1st day of the month, the coverage effective date will be the 1st day of that month.

If you are adding a newly eligible spouse or stepchild(ren) to coverage, other eligible dependents may also be added to coverage, such as your other children. The effective date of coverage for these dependents will be the 1st day of the month following the date of marriage. Your contributions will be due according to the dependent coverage effective date.

If you have previously waived coverage, but you have acquired a newly eligible dependent, (marriage, birth, adoption, etc.), and you want to elect SEHP coverage, you must complete an online Initial Enrollment and submit it to the SEHP along with the appropriate documentation within 31 days of the date of the event.

Coverage for you and your newly eligible dependent(s) will be effective the first of the month following the date of the qualifying event. In the case of a newborn, coverage for the newborn will be the date of birth, but your coverage will be the first of the month preceding the newborn's date of birth. Any other dependents added as a result of this qualifying event will be effective the first of the month following the date of birth of the newborn.

ANNUAL OPEN ENROLLMENT PERIOD

Open Enrollment for SEHP coverage occurs annually during the month of October. When you enroll during the Open Enrollment period, you will have coverage effective the 1st day of the new Plan Year as outlined in the current Health Plan Summary/Open Enrollment booklet.

You must complete the Open Enrollment process to change medical plans, add or drop coverage, add or drop dependents from coverage, or to change pretax payment status. Open Enrollment will be completed via the Internet using the online Kansas employee eligibility portal. Information concerning online enrollment is published prior to the annual Open Enrollment period.

When requesting to add dependents during Open Enrollment, appropriate supporting documentation including valid SSNs or ITINs, must be submitted to SEHP Membership Services by the Open Enrollment deadline. Any documentation submitted in any other language besides English must be accompanied with an English translation. The deadline for submitting the documentation will not be extended.

NOTE: If the information is not provided during Open Enrollment the dependents will not be added to your SEHP coverage in the following plan year. If an ITIN cannot be provided by the annual Open Enrollment deadline, an online Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

For additional information, please contact your Human Resources office.

PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions for you or your dependents that enroll in health coverage during the annual Open Enrollment period. Certificates of creditable coverage from other medical plans are not needed for Open Enrollment.

NEWLY ELIGIBLE MEMBERS

Newly eligible members who have completed their 30 day waiting period may enroll during their initial enrollment period for an effective date of coverage for the current Plan Year. In addition, during the month of October, the member may complete Open Enrollment and elect different coverage to be effective for the new Plan Year.

REVISED OPEN ENROLLMENT ELECTIONS

You may change your original Open Enrollment election during the Open Enrollment period. Following the end of the Open Enrollment period, an online Change request should be submitted by your HR if you have a qualifying event or family status change as listed in this Guidebook. You must notify and have your HR complete an online Change request within 31 days of the qualifying event or family status change. Requests that are submitted without supporting dependent documentation or with incomplete supporting documentation will be denied and notice given to your Human Resources office with no action taken by the SEHP. The deadline for submitting the online request and documentation will not be extended.

IDENTIFICATION CARDS

Identification (ID) cards will be sent to you if you are newly enrolled or if you have made a coverage level change. If you are expecting but do not receive a new ID card by the end of December, you should contact the applicable carrier to request new ID cards be sent. Telephone numbers for the carriers are listed in the front of the Health Plan Open Enrollment booklet.

COST OF COVERAGE

Your contribution for the SEHP coverage is subject to change each Plan Year. Non State Employer contributions are generally subject to change at the beginning of the State of Kansas fiscal year.

SEHP coverage is monthly and rates are based on semi-monthly payroll deduction periods. Coverage termination will be effective the 1st day of the month following termination of employment. Additional premiums are not collected if termination of employment is before the 2nd employee contribution is withheld.

NOTE: For current SEHP rates, please contact your Human Resources office.

MID-YEAR ENROLLMENT CHANGES

ADDITION AND DELETION OF NON-NEWLY ELIGIBLE EMPLOYEES AND DEPENDENTS

Non-newly eligible employees and dependents are defined as employees and/or dependents for which 31 days have passed since their initial eligibility for coverage.

Non-newly eligible employees and/or dependents may be added or dropped from the SEHP during the Plan Year but only if all of the following mid-year change requirements are met:

a. The change is a result of one of the events listed in this Guidebook;

b. You request the change within 31 calendar days of the event by informing and having your HR complete an online Enrollment or Change request;

c. The change in coverage is consistent with the event and complies with HIPAA regulations; and

d. Written documentation of the event is provided (divorce decree, death certificate, custody agreement, or statement from a spouse's employer on their letterhead indicating which dependents are losing or gaining benefits and the date of the loss or gain).

SUPPORTING DEPENDENT DOCUMENTATION

The following appropriate documentation is required to be submitted to the SEHP Membership Services with your Enrollment or Change request:

1. Marriage License (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement for newborns including full names of the parents. (Birth registration cards are not acceptable proof for newborns)
3. Petition for adoption or placement agreement for dependent child
4. Legal custody or guardianship document issued by the court
5. Court order for dependents who are not natural or adopted children of the primary member
6. Certificate of birth and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild).
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older..
8. Copies of the current year's filed Federal tax return (for proof of spouse eligibility only.) Please note all income information may be whited out prior to submission to SEHP Membership Services. The pages needed from the current year's filed Federal tax return depends on which Tax form was filed:
9. Form 1040—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
10. Form 1040A—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
11. Form 8879 (IRS e-file)—containing the date filed, the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
12. Divorce decree (Only the first and last page of the court document are needed, but those pages must include the date stamp by the court and the signature of the judge)
13. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.
14. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

NOTE: Valid SSNs/ ITINs are required when requesting to add dependents. If the information is not provided at the time of the request to add the dependent, the dependent will not be added to your SEHP coverage. If an ITIN cannot be provided, an online Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

Please contact your Human Resources office for additional information.

ADDITIONS:
If you are adding dependent medical coverage, then you many add dependent dental coverage at the same time. If you elect dependent dental coverage, the level of dependent dental coverage must match the dependent medical coverage level.

Vision coverage may be added during the Plan Year only for newly eligible employees and/or dependents. You cannot change from Basic to Enhanced vision coverage, or vice versa during the Plan Year.

If you have waived vision coverage, newly eligible dependents may not be added even if a qualifying event occurs.

DELETIONS:
If you are enrolled on an after-tax basis, you may drop member or dependent coverage (both medical and dental) without restriction during the Plan Year. If you are enrolled on an after-tax basis, you may not change medical plans during the Plan Year.

You many not drop dependent dental coverage during the Plan Year unless you dependent medical coverage.

You many not drop Vision coverage during the Plan Year unless you are an ineligible member and/or dependent. Even if you are enrolled on an after tax basis, vision coverage cannot be dropped during the Plan Year.

EFFECTIVE DATE OF COVERAGE

For mid-year enrollment changes, the effective date of coverage or change in coverage will generally be the 1st day of the month following the event (assuming all requirements have been met). For events that occur on the 1st day of a month, the coverage effective date will be that day. However, if a death occurs on the 1st day of a month, the change effective date will be the 1st day of the following month.

The effective date of coverage is outlined in this Guidebook for newborns, adopted children, new spouses and/or new stepchildren, and changes in legal custody or guardianship of a dependent.

If you are enrolled on an after-tax basis and you are dropping member and/or dependent coverage, the effective date of change in coverage is the 1st day of the month following completion of the online Change request. If the online Change request is completed on the 1st day of a month, the coverage effective date will be that day.

The effective date of coverage or change in coverage is outlined in this Guidebook for changes in Medicare eligibility.

MID-YEAR QUALIFYING EVENTS

Pretax events

If you are enrolled on a pretax basis, and any addition or deletion to coverage will result in a change in employee contribution, there must be a qualifying event for the change to be approved. Enrollment

changes must also be consistent with the event and must comply with HIPAA regulations. You may change pretax status only during Open Enrollment each year (unless the 30-day waiting period was waived for initial enrollment). The qualifying event must result in a gain/loss/change of coverage in an employer-sponsored group health insurance plan. This gain/loss/change can be for you, your spouse, or a dependent and can be under either the SEHP or a plan sponsored by your spouse or dependent's employer. The requested change of election must then correspond with the gain/loss/change of coverage, and must be confirmed with documentation in the form of a letter from the employer on the employer's letterhead. All changes must be requested within 31 days of the event.

If you are enrolled in the SEHP on a pretax basis, you may make mid-year additions and deletions from coverage based on the following events and subject to the requirements listed in this Guidebook:

1. Your marriage – you may add or drop entire family if the family is picked up under the new spouse's employer's plan because the entire family is now newly eligible. The entire family is not newly eligible for SEHP coverage if the spouse's employer covered unmarried domestic partners. If the marriage is a common law marriage, a notarized copy of The Affidavit of Common Law Marriage must be included with the Enrollment or Change request.

2. Your final divorce (the first and last pages of the final divorce decree, which includes the date stamp by the court and the signature of the judge must be attached to the Enrollment or Change request).

3. Birth or adoption of a dependent – you may add your entire family. You may drop entire family only if the status change is due to a birth or adoption, and those family members are now newly eligible under some other employer's plan.

4. Gain or loss of legal custody of a dependent.

5. Change from part-time to full-time or from full-time to part-time employment by your spouse or dependent that affects cost, benefit level, or benefit coverage for you, your spouse and/or dependents. Change from benefits eligible position to benefits ineligible position by you, your spouse or dependent. Termination or commencement of employment (includes retirement) of you, your spouse or dependent which affects benefits coverage for you, your spouse and/or dependents (you may change your medical plan at the time of retirement). Any employment status changes that affect eligibility.

6. Significant changes in the health insurance coverage of you, your spouse or dependent. Change of Network Status of a physician is not a qualifying event. You may make a mid-year change due to an Open Enrollment change made by a spouse or dependent on their health plan.

7. If you, your spouse or dependent are called to active military duty and/or gain or lose eligibility for military insurance.

8. Loss of COBRA eligibility (for other than non-payment of premium) from a previous employer for you, your spouse or dependent.

9. Death of your spouse or dependent.

10. Your dependent child turns age 26 (coverage will end for your dependent the last day of the month of their birthday). If the birth date is on the first day of a month, the coverage ending date for your dependent will be the last day of the preceding month.

11. If you, your spouse or dependent gain or lose government-sponsored medical card coverage. Terminating coverage is not allowable if you become covered under programs

like SCHIP (State Children's Health Insurance Program) because these programs are not supposed to replace existing insurance. This may apply to other government card coverage.

12. If you, your spouse or dependent lose Medicare eligibility or become eligible for Medicare, and elect Medicare coverage as primary.

13. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order (the SEHP has the authority to add these dependent children without the consent of the employee).

14. Court Order requiring adding or dropping coverage for a dependent child.

15. Dependent children losing eligibility/coverage under another group health insurance plan.

16. Children that change from non-dependent to dependent status during the Plan Year under SEHP guidelines can only be added back on to your coverage at Open Enrollment.

17. Dependent spouse or children who move to the U.S.

After-tax events

If you are enrolled in SEHP coverage on an after-tax basis, you may make mid-year additions and deletions from coverage due to the following events and subject to the requirements listed above:

1. All events as listed under Pretax Events;
2. Removing yourself and/or dependents from SEHP coverage for any reason (no documentation is required).
3. Vision coverage may not be added or dropped during the Plan Year.

ACTIVE MILITARY DUTY

If you go on military duty - leave without pay, you may continue coverage for the next 30 days. Your employer will continue to make the SEHP employer contribution for those 30 days. You must pay your premium (regular payroll deduction amount) to your non to continue your coverage during the 30 days following the effective date of the military leave without pay.

You may continue coverage in the SEHP beyond the 30 days leave without pay timeframe, but you must pay the full premium amount directly to the premium billing vendor as a direct bill participant. There will be no Employer contribution. An employee with spouse, children, or full family coverage may elect to drop themselves and keep their spouse and/or children covered in the SEHP. You must make the change within 30 days of the effective date of the military leave without pay. To continue SEHP coverage, an online Change request indicating Leave Without Pay must be completed and submitted to the SEHP Membership Services.

If SEHP coverage is continued, it will be the primary payer of claims and their military coverage will be secondary.

You and/or your dependents who elect to discontinue SEHP coverage and who have primary coverage provided by the military will be allowed to reenroll into the same SEHP plan and coverage when you return to active employee status.

If you are on military leave during Open Enrollment, you may enroll in any SEHP plan and coverage levels for which you are eligible, without penalty, upon your return to active employee status.

The effective date of coverage may be either the first day of the month following your return from active military duty or the first day of the month in which you return to active employee status.

If you are qualified for and elect to participate in the military's transitional health benefit program, you will be allowed to reenter the SEHP without penalty when the transitional coverage terminates. You may be qualified for up to 180-days of transitional health benefits.

The effective date of coverage may be either the first day of the month following termination of the military transitional health coverage or the first day of the month in which the military coverage terminates, whichever you choose.

Return from military leave policies also apply to dependents returning from military leave.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH HSA - (QHDHP W/HSA)

THE DIFFERENCE BETWEEN PLAN C – QHDHP W/HSA AND PLANS A AND B

- Premiums paid for coverage are lower.
- The deductible you must pay under Plan C is higher, but you and your employer will make a contribution to your Health Savings Account that can be used to help you meet your deductible.
- With Plan C, the Caremark Preferred Drug List is the same as with Plans A and B however, the benefits are different.

  Note: *Prescription drugs are subject to the overall plan deductible. Also, under Medicare Part D rules, Plan C drug coverage is* ***now*** *considered "creditable coverage".*
- Plan C drug coverage includes a generic incentive program. Members who have generics available to them will pay more for brand name drugs.
- When you choose dependent coverage under Plan C, a family member may now satisfy the single deductible for claims to be paid versus the entire family deductible having to be met as in prior years.
- Most covered services are subject to the deductible.
- For members 65 and over, you are eligible to elect Plan C and contribute to an HSA as long you have not:
  - Applied to receive Social Security benefits, which automatically includes Medicare Part A coverage and / or:
  - Enrolled in Medicare Part B or D

HEALTH SAVINGS ACCOUNT (HSA)

The HSA is a required part of the QHDHP with minimum and maximum allowable contributions. The purpose of the HSA is to allow members to put tax advantaged savings aside for future medical expenses. The savings may be used for certain premiums, copayments, coinsurance, deductibles or any medical expenses that are not covered by the QHDHP.

The HSA is owned by the member, administered by the HSA bank, and can be funded up to the maximum amount determined by the U.S. Treasury Department each year. Members age 55 and over can make an annual “catch up” contribution of $1,000, as outlined in IRS Publication 969. The HSA account is portable and funds rollover from year to year.

New employees who enroll in the QHDHP will have their HSA opened through US Bank (see Open Enrolment booklet) by completing their HSA Enrollment application or by signing up online within 31 days of their date of hire. You must log on to your HSA online and accept the terms and conditions of the account to have access to your funds.

Your employer should also contact the HSA bank in order to send contributions (both the employer and employee contributions) to your account each pay cycle.

HSA contribution changes can be made during the year without a qualifying event. If no change is made, the same contribution amount will continue into the next Plan Year.

Both employer contributions for 2014 will be based on your status as of January 1st, even if you experience a status change during the year.

Note: Please contact your employer regarding how employer contributions will be made.

HSA BANK CONTACT INFORMATION

- US Bank (this is the HSA bank for all three health vendors): 877-470-1771, or online at: www.mycdh.usbank.com

For more information concerning Plan C - HSA benefits, please contact SEHP Membership Services at 785-368-6341.

IMPORTANT INFORMATION WHEN TRAVELING OUTSIDE OF THE U.S.

You should contact your medical plan carrier **before** traveling outside of the U.S. for coverage and claim submission requirements in the event that you and/or your eligible dependents need to seek medical treatment while traveling outside of the U.S. Each medical plan carrier has their own processes and procedures to ensure you and your eligible dependents have appropriate coverage while traveling.

PRESCRIPTION DRUG ADVANCE PURCHASE POLICY:

A. Travel in the United States
Because the SEHP uses the Caremark Pharmacy network, when you are traveling within the United States, you are not eligible for an advance prescription purchase. You may use your drug card at any Caremark network pharmacy throughout the U.S.

B. Travel Outside of the United States
   a. Travel or work outside the U.S. for a period of sixty (60) days or less:
   When you plan to leave the U.S. for 60 days or less you may call the toll-free number on the back of your card to arrange for a vacation supply of medications. Caremark may enter up to 30 days on an original fill for non-controlled and controlled medications or a 60 day override on refills of medications as allowed by the benefit description. You will be billed the applicable coinsurance or copayment for the quantity purchased.
   b. Work outside the U.S. for a period of sixty (60) days or longer but not to exceed one [1} year:
   This policy and its provisions apply only to active employees covered under the SEHP. When you will be outside of the country for a longer period of time, there are two options available:

- **Advance purchase through drug plan:**
  You must work with your Human Resources office to arrange for advance purchase of maintenance medications required during a stay outside the U.S. The Advance Purchase Certificate certifying that health coverage will be maintained during the entire period of the extended absence must be signed by both you and your employer. An Advance Purchase Form must be submitted to SEHP Membership Services **at least fifteen (15) days prior to your departure date**. You and your employer will be notified when the Advance Purchase Form has been processed and the dates the medication will be available to pick up. Generally, the medication will be available for purchase one week in advance of the departure date. The following requirements apply:

    1. The Advance Purchase form must be completed stating that coverage will be maintained via payroll deductions during the term outside of the U.S. The form also requires information on your destination and duration of stay. The Advance Purchase form signed by you and your Human Resources representative acknowledges the SEHP's right to recovery from you and/ or your employer the cost of the medications if coverage is not maintained.
    2. The name and strength of each requested medication and the name of the prescribing doctor must be on the Advance Purchase form. For each medication, provide the name of pharmacy where the medication will be filled. You will be responsible for the applicable coinsurance percentage on the cost of the quantity of drug dispensed. You must agree to purchase the prescription medication at a local network pharmacy. You or your dependents using the Caremark mail service will need to obtain a prescription from your doctor so that the items can be purchased at a local network pharmacy.

REMINDER: Medication can only be dispensed for the period of time allowed by the prescription written by the provider. For extended periods, the member may need a new prescription. Advance purchases are available for period up to one (1) year.

3. Benefits available for emergency prescriptions purchased outside of the U.S. will be limited to those drugs which would have been covered had they been purchased within the U.S. Documentation of the purchase must be translated into English along with the exchange rate on the date of service and be submitted to the SEHP on a paper form with a statement indicating their purchase and use while outside of the U.S. Your membership status will be verified and the claim will be forwarded to Caremark for reimbursement.

- **Member purchases medication(s), then submits claim(s) upon return:**
  If you do not have enough time to file an Advance Purchase Form in advance of your departure, you may pay the full price for your medications, and file a paper claim for reimbursement upon your return. The paper claim would need to be sent first to SEHP for processing.

Please contact your Human Resources office for additional information.

HEALTHQUEST PROGRAM

HealthQuest is the wellness program for benefits-eligible employees and their spouses who are enrolled in the State Employee Health plan. As part of your benefits plan, a variety of services are offered at no additional cost. Participation in HealthQuest programs is always voluntary and strictly confidential. The toll-free telephone number for HealthQuest programs is 1-888-275-1205, TTY 1-888-277-1543. For full details on HealthQuest programs, please visit www.kdheks.gov/hcf/healthquest.

Wellness Services

- **Nurse Line** - A team of nurses is standing by to take your call 24 hours a day, 365 days a year. Access Nurse24 for any health related question by calling toll-free 1-888-275-1205 (option 2).
- **Wellness Portal** - Register an account at www.KansasHealthQuest.com to access customized healthy living programs, fun wellness challenges, healthy recipes and more, plus earn credits for the Rewards Program!
- **Health Coaching** - Get ongoing support from a personal coach for making positive lifestyle changes. Enroll by calling 1-888-275-1205 (option 4).
- **Condition Management** - If you are dealing with asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes or heart failure, personal coaching support is available to help you manage your condition and achieve a better level of health. Call 1-888-275-1205 (option1).
- **Tobacco Cessation** - Enroll in the nation's leading tobacco cessation program and work with a Quit Coach on your individual quit plan. Receive an eight-week supply of nicotine replacement patches or gum (if appropriate) at no cost to you. Call 1-888-275-1205 (option 3).
- **Statewide Biometric Screening Events** - As part of the commitment to help you lead a healthier lifestyle, HealthQuest sponsors biometric screenings at worksites across the state. This program provides:
  - Cholesterol (HDL & LDL), triglycerides and glucose with a finger stick test
  - Blood pressure, measured height and weight and BMI calculation
  - Current biometric values to fill out your health assessment questionnaire
- **Health Assessment Questionnaire** - The health assessment online tool can help you take an active role in managing your health. Complete the health assessment questionnaire once per program year using current biometrics values to receive a personal health management plan developed just for you.
- **Rewards Program** - Employees enrolled in the medical portion—of the State Employee Health Plan have an opportunity to earn a discount on their health insurance premium through the HealthQuest Rewards Program. The HealthQuest program year (also known as the earning period for the discount) runs from August 1 through July 31. Because the requirements to earn a discount may change from year to year, please refer to the HealthQuest website for full details on the current Rewards Program, including a flyer for new health plan members: http://www.kdheks.gov/hcf/healthquest/rewards.html

Employees will need to set up a HealthQuest account on the wellness portal to begin earning credits toward their discount. As a general guideline, new members should have access to the HealthQuest programs within two weeks of submitting their health insurance paperwork (they do not have to wait until their coverage

begins). Instructions for registering an account are provided at:
http://www.kdheks.gov/hcf/healthquest/download/How_to_Register_an_Account.pdf

- **Who is Eligible to use the Wellness Services?**

  - Benefits eligible State and Non State employees who are enrolled in the State Employee Health Plan or who have waived coverage in the plan
  - Retirees and spouses who are enrolled in the medical portion of the State Employee Health Plan

Employee Assistance Program (EAP)

With a single call to the EAP, you and your family members receive confidential assistance, 24 hours a day, 7 days a week at no cost to you. Call confidentially 1-888-275-1205 (option 7), TDD/TT 1-800-697-0353. Full details on the EAP services, please visit www.kdheks.gov/hcf/healthquest/eap.html.

- **Confidential Personal Counseling** - The HealthQuest EAP provides short-term counseling to you, your spouse, and your dependents for a wide variety of personal and family concerns. Counseling is provided in your area by licensed and experienced professionals. You will find the counselors at the EAP to be knowledgeable about real life problems, very caring, and readily available. A few of the most common reasons employees use the EAP Personal Counseling service include:

  - Family & Parenting Concerns
  - Marital & Relationship Issues
  - Improving Communications & Self-Esteem
  - Stress, Anxiety & Depression
  - Work-Related Concerns
  - Alcohol & Substance Abuse Problems
  - Grief & Loss
  - Major Life Event Changes

- **Work-Life Solutions -** The EAP staff of referral specialists will help you complete your “to-do” list by providing qualified referrals and customized resources for things like:

  - Child & Elder Care
  - Moving & Relocation
  - Making Major Purchases
  - College Planning
  - Pet Care
  - Home Repair

- **Legal Advice & Discounts** - The EAP provides a confidential telephonic legal consultation with an attorney who specializes in the area of your concern at no charge. If you need legal representation, you will be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in the customary legal fees thereafter. The most common requests include:
  - Divorce & Family Law
  - Consumer & Bankruptcy Issues
  - Real Estate Transactions
  - Landlord & Tenant Disputes
  - Wills And Estate Planning Questions
  - Criminal/Civil Lawsuits
- **Personal Money Management Advice** - The EAP program provides employees and their family members with access to financial specialists with a broad range of experience in personal financial services. Call anytime for a consultation on topics such as:
  - Home Budgeting
  - Retirement Questions
  - Debt Consolidation
  - Tax Issues
  - Credit Matters
  - Investments
  - College Funding
  - Estate Planning
- **Guidance Resources Online -** Guidance Resources Online is your one stop for expert information on the issues that matter to you…relationships, work, school, children, legal, financial, free time and more. Access articles, watch videos, conduct searches and get personal responses to your questions in one location.
- **Who Is Eligible to Use the EAP Program?**
  - All active, benefits-eligible employees of the State of Kansas, their dependents and other family members living in the same household
  - All active , benefits-eligible employees of our Non State Employer Groups, their dependents and other family members living in the same household

CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

Eligible members may continue coverage through the SEHP after they retire from the participating Non State Employer Group. Coverage will continue in the SEHP for as long as the participating Non State Employer Group is covered under the Plan. If a participating Non State Employer Group elects to terminate coverage in the SEHP, the Direct Bill members from that Non State Employer Group would be terminated as well.

NOTE: If a retiree is hired by a participating Non State Employer Group and did not previously retire from an employer that was part of the SEHP, the retiree may not participate in the SEHP Direct Bill program upon terminating employment from the Non State Employer Group because they did not retire from the State of Kansas originally.

The following members are eligible to continue under the SEHP Direct Bill Program:

Subject to the provisions of subsection (e) of K.A.R. 108-1-3 and 108-1-4, the classes of persons eligible to participate as members of the SEHP on a Direct Bill basis shall be those classes of persons listed below:

A. Any retired school district employee who is eligible to receive retirement benefits;
B. Any totally disabled former school district employee who is receiving benefits under K.S.A. 74-4927 and amendments thereto;
C. Any surviving spouse or dependent of a qualifying member in the school district plan;
D. Any person who is a school district employee and who is on approved Leave Without Pay in accordance with the practices of the qualified school district;
E. Any individual who was covered by the health care plan offered by the qualified school district on the day immediately before the first day on which the qualified school district participates in the school district plan, except that no individual who is an employee of the qualified school district and who does not meet the definition of school district employee in K.A.R 108-1-3
F. Any retired local unit employee who meets one of the following conditions:
    1) The employee is eligible to receive retirement benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or
    2) if the qualified local unit is not a participating employer under either the Kansas Public Employees Retirement system or the Kansas police and firemen's retirement system, the employee is eligible to receive retirement benefits under the retirement plan provided by the qualified local unit.
G. Any totally disabled former local unit employee who meets one of the following conditions:
    1) The employee is receiving benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or
    2) if the qualified local unit is not a participating employer under either the Kansas Public Employees Retirement system or the Kansas police and firemen's retirement system, the employee is receiving disability benefits under the retirement or disability plan provided by the qualified local unit.
H. Any surviving spouse or dependent of a qualifying member in the local unit plan
I. Any person who is a local unit employee and who is on approved Leave Without Pay in accordance with the practices of the qualified local unit; and
J. Any individual who was covered by the health care plan offered by the qualified local unit on the day immediately before the first day on which the qualified local unit participates in the local unit plan, except that no individual who is an employee of the qualified local unit and who does not meet the definition of the local unit employee in K.A.R. 108-1-4.

CONDITIONS FOR DIRECT BILL MEMBERS

If you are within a class listed above, you will be eligible to participate on a direct bill basis only if you meet the following conditions:

1. If you were covered by the qualified school district plan or the health care insurance plan offered by the qualified school district on one of the following bases:

    a) Immediately before the date you ceased to be eligible for coverage, or if you were a person identified in paragraph E above immediately before the first day on which the qualified school district participates in the school district plan, you either were covered as an active member or covered by the health care insurance plan offered by your qualified school district.
    b) You are a surviving spouse or dependent of an active or Direct Bill member who was enrolled when they died, and you were enrolled in the health care benefits program as a dependent when they died.
    c) You are a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by their qualified school district when they died, and they maintained continuous coverage under their qualified school district's health care insurance plan before joining the health care benefits program.

Note: Your HR representative must complete an online Change request to transfer you onto the Direct Bill program. You must then go onto the Initial Enrollment portal and submit your Direct Bill elections to SEHP Membership Services. The request must be submitted no more than 30 days after you ceased to be eligible for coverage, or in the case of any individual identified in paragraph E, no more than 30 days after the first day on which the qualified school district participates in the school district plan.

2. If you were covered by the qualified local unit plan or the health care insurance plan offered by the qualified local unit on one of the following bases:

    a) Immediately before the date you ceased to be eligible for coverage, or if you were a person identified in paragraph J above immediately before the first day on which the qualified local unit participates in the local unit plan, you were either was covered as an active member or covered by the health care insurance plan offered by your local unit.
    b) You are a surviving spouse or dependent of an active or Direct Bill member who was enrolled when they died, and you were enrolled in the health care benefits program as a dependent when they died.
    c) You are a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by their qualified local unit when they died, and they maintained continuous coverage under their qualified local unit's health care insurance plan before joining the health care benefits program.

Note: Your HR representative must complete an online Change request to transfer you onto the Direct Bill program. You must then go onto the Initial Enrollment portal and submit your Direct Bill elections to SEHP Membership Services. The request must be submitted no more than 30 days after you ceased to be eligible for coverage, or in the case of any individual identified in paragraph J, no more than 30 days after the first day on which the qualified local unit participates in the local unit plan.

RETIREMENT

When you retire from employment, your Human Resources representative will need to complete an online Change request indicating that you are retiring and whether or not you wish to continue SEHP coverage through the Direct Bill program. If you wish to continue coverage, you must then go onto the Initial Enrollment portal and submit your Direct Bill elections to SEHP Membership Services. You must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the

Change request should be completed 90-days before your retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage.

The effective date of change to the Direct Bill program will be the 1st day of the month following your last day in pay status, unless your last day is the 1st of the month, then your effective date will be that same day.

You may change your medical plan at the time of retirement. Your dependents may be dropped from coverage upon retirement; however, your dependents may be added to coverage only if there is a qualifying mid-year event. Qualified dependents may also be added to coverage during the next Open Enrollment period.

You may opt out of dental coverage at retirement or Open Enrollment. **NOTE: Once you opt out of dental coverage, you will not be able to re-enroll in dental coverage at a later date. The exception to this rule is if you would return to active employment.**

Vision coverage may not be dropped during the plan year unless due to a dependent becoming ineligible or unless all coverage is terminated. If dependent medical coverage is dropped, dependent vision coverage can be dropped. You may choose to keep your vision coverage even if you drop both medical and dental.

Important note: If you have retired after January 21, 2001, you do not have the option to re-enroll in the SEHP after you drop SEHP coverage. Retiring employees will be allowed to re-enroll only if they maintain continuous coverage under the SEHP as a dependent.

RETIREES AND MEDICARE ELIGIBILITY

Employees and spouses who are age 65 at retirement, or eligible for Medicare due to disability
If you or your covered spouse is age 65 or over when you retire, you must apply for Medicare Part A and Part B if you do not currently have both Parts. Your enrollment into Direct Bill cannot be processed without this card. The Social Security Administration requires that your Non State Employer provide you a memo or letter with health insurance information necessary to process the application for Medicare Part B coverage. When applying for Medicare Part B, you should present the memo or letter to the local Social Security Office.

Required information in the memo or letter is:

- Statement that you are covered under the SEHP,
- Date your coverage began,
- Date your coverage ended or will end, and
- Your spouse's name and Social Security Number if your spouse is covered by the SEHP.

Please note the letter or memo must be on your employer's letterhead.

When you are Medicare Eligible:
As a Medicare eligible retiree or member, you have 7 medical plans from which to choose:

- Coventry Advantra Freedom PPO with Coventry Part D
- Coventry Advantra PPO with First Health Part D
- Kansas Senior Plan C with First Health Part D
- Kansas Senior Plan C without First Health Part D
- SEHP Plan A with Caremark prescription drug coverage
- SEHP Plan B with Caremark prescription drug coverage
- SEHP High Deductible Plan C with Caremark prescription drug coverage

Information on these plans can be found on the SEHP website at:
www.kdheks.gov/hcf/sehp/directbill.htm

When you and your covered spouse are both Medicare eligible:
If you and your covered spouse are both Medicare eligible, you will have the same 7 medical plans available as those listed above. When Medicare is an option, you and your spouse will be enrolled in separate plans.

SPLIT ENROLLMENT

Split Enrollment is required for the following situations:

1. When you and your spouse are both Medicare eligible
2. When you are Medicare eligible and your spouse/dependents are not Medicare eligible
3. When you are not Medicare eligible and your spouse/dependents are Medicare eligible

When Split Enrollment occurs, the Medicare member(s) may enroll in one of the following plans:

- Coventry Advantra Freedom PPO with Coventry Part D prescription drug coverage
- Coventry Advantra PPO with First Health Part D prescription drug coverage
- Kansas Senior Plan C with First Health Part D prescription drug coverage
- Kansas Senior Plan C without First Health Part D prescription drug coverage
- SEHP Plan A with Caremark prescription drug coverage
- SEHP Plan B with Caremark prescription drug coverage
- SEHP High Deductible Plan C with Caremark prescription drug coverage

The non-Medicare member remains in one of the SEHP's Plan A, Plan B, or High Deductible Plan C options.

Special Note on Dental coverage for:

1) **Members that must split their coverage, or**
2) **Enrolling as a surviving spouse or dependent:**

If your spouse or dependent is not currently enrolled in dental coverage at the time coverage is split, or when enrolling as a surviving spouse or dependent, your spouse/dependent has a one-time option of picking up the dental coverage at the next Open Enrollment following this qualifying event.

Information on these plans can be found on the SEHP website at: www.kdheks.gov/hcf/sehp/directbill.htm

PAYMENT METHODS UNDER THE DIRECT BILL PROGRAM

Premiums for your Direct Bill coverage are administered by third party billing administrators. You will receive a bill for the 1st full month in retirement status if bank draft information is not received in time to get the automatic bank draft started. Once set up, you have several ways to pay your SEHP premiums. Methods may include automatic bank draft, payment on line, payment via credit card over the telephone or payment via check or money order.

Currently, HP-Hewlett Packard-Member Services bills SEHP Direct Bill members for all SEHP premiums with the exception of Part D prescription drug coverage through First Health. If you have your Part D prescription drug coverage through First Health, you will be billed directly by them.

Payments for your SEHP premiums are due the first of the month for that month's coverage. For example, January premiums are due to the premium billing administrator by January 1. If premiums are not paid by the first of the month, your coverage may be terminated and may not be reinstated.

For additional information concerning the Direct Bill program, you or your Human Resources representative should contact:

Membership Services
State Employee Health Plan
900 SW Jackson, Suite 900
Topeka, Kansas 66612-1220

Telephone:
785-296-1715 (In Topeka)
1-866-541-7100 (Toll Free)

Fax: 785-368-7180

CONTINUATION OF COVERAGE - COBRA

The federal COBRA law was enacted in 1986. The law requires that most employers sponsoring Group Health Insurance Plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

If you and your dependents lose insurance coverage under the SEHP, you have the right to elect to continue coverage by paying the required premiums. (Under **COBRA**, if you are a retiree or are covered through the Direct Bill program, you also have the same continuation rights as active employees.). If you are a retiree and have chosen COBRA over the SEHP Direct Bill coverage and COBRA runs out, you may enroll in Direct Bill coverage. **NOTE**: You may not elect to have both Direct Bill and COBRA coverage at the same time. You may only have one or the other.

You, your spouse, and your dependents that are eligible to continue health insurance coverage are called Qualified Beneficiaries. The provisions under which you can continue coverage are called Qualifying Events. The number of months you can continue coverage is specified.

HEALTH COVERAGE TO BE CONTINUED

Qualified beneficiaries are eligible to continue only those medical, dental, prescription drug and vision benefits in which you were covered by at the time of the qualifying event.

NOTE: If you go on Leave Without Pay (LWOP), then terminate employment AND do not continue SEHP coverage during the leave period, then you and any dependents will **NOT** be eligible for COBRA continuation. You are not eligible because you were not participating in the SEHP at the time of the qualifying event.

PROCEDURES TO BE FOLLOWED WHEN YOU EXPERIENCE A COBRA QUALIFYING EVENT

1. If the qualifying event is termination of employment (except for gross misconduct), the SEHP must notify your medical plan that termination of insurance coverage has occurred. Because there is a time limit in which you can elect to continue coverage, your employer must immediately notify SEHP Membership Services of your termination of employment so that the SEHP Membership Services can cancel your coverage.

2. If the qualifying event is the reduction of hours of work to less than 1,000 per year, the SEHP must notify your medical plan that termination of insurance coverage has occurred. Because there is a time limit in which you can elect to continue coverage, the online Change request must be immediately forwarded to the SEHP Membership Services.

3. If the qualifying event is because of 1) your death (active employee & Direct Bill); 2) Your divorce (active employee and Direct Bill); 3) You choose Medicare as primary carrier leaving dependents without health insurance coverage (active employees ONLY); or 4) your dependent ceases to meet the SEHP's definition of dependent, i.e. turns age 26 (active employee & Direct Bill), the qualified beneficiary must notify your employer's Human Resources office **within 60 days** of the qualifying event. (Spouses and dependents of retirees should notify the SEHP **within 60 days** of the qualifying event). If notice is not received within 60 days of the qualifying event, the beneficiary will **not** be eligible for continuation coverage. Because of this time limit, the online Change request must be transmitted immediately to SEHP Membership Services.

4. Within 21 days of SEHP Membership Services receiving notification of the qualifying event, the qualifying beneficiary will receive specific information, including a COBRA Enrollment Form setting forth

the requirements for continuing insurance coverage, the plans available, and the applicable premium rates from the SEHP COBRA administrator.

5. An election by you or your spouse to continue coverage will be deemed to be an election for coverage by any other qualifying beneficiary. However, each qualifying beneficiary has an individual right to select continuation coverage. Each beneficiary may make a separate selection among the levels of coverage available.

ADMINISTRATIVE ISSUES

SEHP benefits will generally terminate on the last day of the month in which the qualifying event occurs. COBRA notices are generated by the SEHP's COBRA administrator following notice of your termination from your employer. Notification of your termination is required from your employer via an online Change request submitted to SEHP Membership Services. If the online Change request is received from your employer and not processed, the qualified beneficiary will not receive a letter. Timeliness becomes a critical issue when having your Human Resources office complete and submit online requests.

COBRA continuation is not automatic - it is a choice that the qualified beneficiary must make. Also, the online Change request does not activate COBRA continuation status. The qualified beneficiary must complete the COBRA election form that accompanies the COBRA notification letter sent by the COBRA Administrator. The qualified beneficiary has 60 days from the date of the COBRA notice to return the COBRA continuation election form to the COBRA Administrator.

COBRA notification letters will be sent to the qualified beneficiary at their last known address. It is important at the time of termination that you make sure that your employer has your correct address. You should remember that if you move, that you leave forwarding instructions at the Post Office.

COST OF BENEFITS - COBRA CONTINUATION RATES

Any qualified beneficiary who elects to continue coverage under the plan must pay the full cost of that coverage (including **both** the share you paid as an active employee, and the share paid by your employer), **plus** any additional amounts allowed by law. At present, COBRA Continuation rates are 102% of total premium. Those beneficiaries who elect the 11-month extension of benefits due to disability will pay 150% of premium for the additional 11-months of coverage.

Please go to the SEHP web site for the current plan year COBRA rates.

www.kdheks.gov/hcf/sehp/COBRA.htm (look under "Non-State COBRA Rates")

TERMINATION OF COVERAGE CONTINUATION

You and/or your eligible dependents will lose continuation of SEHP under COBRA if:

1. You do not pay or do not make timely payment of premiums;
2. You or your dependent(s) become(s) covered, either as an employee or dependent, under another employer-provided medical plan which does not limit or exclude coverage for preexisting conditions (does **not** apply to the surviving spouse in qualifying event I);
3. You or enrolled dependent(s) become eligible for Medicare (has enrolled in the Medicare program). However, if Medicare eligibility is due to ESRD, the individual may continue on COBRA.
   NOTE: **Only the person(s) eligible for Medicare coverage lose(s) COBRA Continuation benefits. Any other person(s) enrolled may continue for the duration of the COBRA eligibility period; or**
4. The State of Kansas no longer offers group health insurance to its employees.

For more information contact your Human Resources office.